



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE-DALLAS
PO BOX 11527
HOUSTON TX 77293

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TASB RISK MGMT FUND

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-08-2401-01

MFDR Date Received

DECEMBER 14, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the position of Renaissance Hospital that the Respondent has not reimbursed these services at a fair and reasonable rate as required in TDI-DWC Rule §134.401... It is our position that the Carrier has failed to prove our PAF is not fair and reasonable, and thus Renaissance Hospital has met it's 'burden of proof in this case..."

Amount in Dispute: \$21,992.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC has ruled... that 213.30% of Medicare fee schedules is fair and reasonable for ambulatory surgical centers. We feel our established allowance of 230% of Medicare's fee schedule is fair and reasonable for outpatient surgical services as those services are comparable to services provided by an ambulatory surgical center... TASB has established a consistent methodology to reimbursement this type of bill for which there is no DWC fee schedule and we are standing by our original determination."

Response Submitted by: TASB, PO Box 2010, Austin, TX 78768

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2007	Outpatient Hospital Services	\$21,992.24	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Preauthorization was for outpatient only.
 - W10 – No maximum allowable defined by fee guideline. Reimbursement made has ed [sic] on insurance carrier fair and reasonable reimbursement methodology. Paid at 100% from invoices.
 - 97 – Payment is included in the allowance for another service/procedure. Global to Surgery (Revenue Codes 360).
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "It is the position of Renaissance Hospital that the Respondent has not reimbursed these services at a fair and reasonable rate as required in TDI-DWC Rule §134.401... It is our position that the Carrier has failed to prove our PAF is not fair and reasonable, and thus Renaissance Hospital has met it's 'burden of proof in this case...'"
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under

Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	October 26, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.